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The Unfunded Liability Myth:

Medicare, Medicaid, Social Security funding: A solution born of the inevitable.

It is no secret that the current obligations of the federal government for Medicare, Medicaid, and Social Security are unsustainable. Each year, especially during political season, it is a hot topic. And each year nothing is done to address it. TV analysts are continually talking about the system “going broke”, raising taxes, and so on, but nothing changes, why not? The reality is that these programs are not insolvent, they are not unfunded, and they will exist long into the future—far beyond the lives of anyone reading this article. As an industry serving seniors, and as providers within this industry, we need to recognize where these programs are going, and get there before it is too late.

The Programs:

Medicare is the “social insurance program” created and administered by the federal government of the United States of America to individuals 65 and older. Medicare was created by The Social Security Act of 1965 and signed into law on July 30, 1965, by President Lyndon B. Johnson as amendments to the existing Social Security legislation. Products and services covered by Medicare parts A through D are things such as hospital visits, short term stays in skilled nursing facilities, outpatient services, durable medical equipment, and prescription drugs. The estimate as of Fiscal Year 2009 for the “unfunded obligation” (i.e. the benefits promised with no money identified to keep those promises) of Medicare, over an infinite time horizon (i.e. assuming the program goes on at its current benefit level forever) was approximately $86 trillion, or a mere $34 trillion if you take a 75 year time horizon. Stated in a different way, it would require $34 trillion for the federal government to keep its promises to taxpayers.

Medicaid is a much more complicated program than Medicare or Social Security so I will simplify it to its most essential parts. In essence, Medicaid is a program administered jointly by the federal government and each individual state for families and individuals with low income and assets. Medicaid was created by the Social Security Act of 1965, and the majority of its funding goes towards services for the aging and disabled. Estimating the “unfunded obligation” for Medicaid is much trickier than with Medicare or Social Security for two reasons; First, there is no “Medicaid Trust” as there is with Medicare and Social Security, but rather funding for Medicaid comes from general funds (i.e. the tax revenue in a given year) which fluctuates. Secondly, because Medicaid is jointly administered between the federal government and each individual state, the unfunded portion varies wildly between states. So while we cannot put an exact number on the unfunded portion, it is safe to say that Medicaid, and especially the long term care portion, is a very large number. If we simply take the total number of people added to Medicaid over the next 30 years, 32 million, and multiply by the average cost for nursing home care, $70,000 per year, we get a total of over $2.2 trillion. This of course doesn't take into account accrual of costs (i.e. a

beneficiary receives services for more than one year), but this is inconsequential to the outcome of these programs and our necessary response.

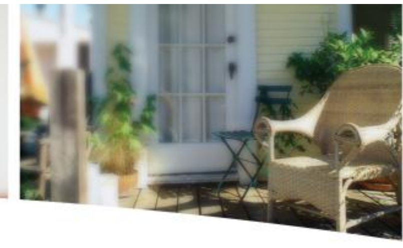
Though technically Social Security includes Medicare and Medicaid, the term is typically used to refer to the Federal Old-Age (Retirement), Survivors, and Disability Insurance portion (i.e. "my social security check"). This program was originally created by the Social Security Act of 1935, and signed into law by President Franklin D. Roosevelt. The current estimates of the unfunded portion of Social Security over an infinite time horizon are $18 trillion.

To summarize, that is over $106 trillion in "current unfunded obligations" for Medicare and Social security, and one big scary question mark for Medicaid. It is easy to see how these numbers and "realities" get thrown around in political banter. They have a high emotional intensity because they invoke fear, and this fear is often used to drive home particular ideological points.

On the rare occasion that a solution is offered to this looming time bomb, it is typically one of two options. I don't believe that either of these are in the realm of reality, so I will present a third option that is obvious and actionable.

The "Supposed" Solutions:

1. Eliminate the programs entirely. Most often this is not stated explicitly but it underlies much of the rhetoric that is used. Close your eyes and imagine the television ads that would run of a senator or representative that voted to shut down any one of these programs! It should be painfully obvious why this will never happen, no matter how much this option is used in political rhetoric. Right, wrong, or indifferent (it is not my place to say) there is not, nor never will be the political will in this country to shut off these programs completely.
2. Raise taxes. Again this is used as political rhetoric to polarize voters to a particular side of the ideological aisle, but let's look at the viability of this solution. First, the dollars that are taxed do not go directly to these programs, they go into the general fund (even when they go into the Medicare and Social Security Trust they are tapped for general operating expenses and projects), which Congress people then jockey and fight over to fund different programs and projects. At best a relatively small portion of each additional tax dollar would go to closing the funding gap on these programs. In short this would mean that taxes would need to bring in some multiple of the $106+ trillion liability to close the gap. Second, no matter what side of the political isle you are on, there is simply not enough money to be taxed (no matter how creative the tax program suggested) to close this gap.



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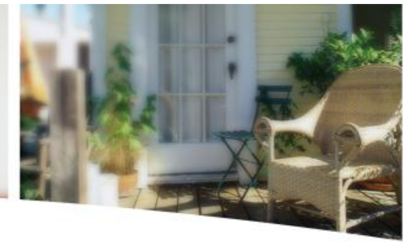
I would like to suggest that Medicare, Social Security and Medicaid are not truly unfunded. I would like to suggest that the course of these programs was determined the moment they were signed into law and it is within this course that we as providers find our solution.

3. Gradually erode benefits and squeeze providers. These programs are already funded, it is simply that we do not know exactly what will be cut and when, but this is the unspoken reality of the situation. Senators and Representatives are able to chip away at benefits, provider reimbursements, and provider requirements without any need for new legislation or political will. This process has already begun, and the way it looks goes something like this; "There will be no increase from Medicare for outpatient therapy services in Fiscal Year 2010", or "Medicare will be issuing a new case mix fee schedule for Fiscal Year 2011", or "Providers are expected to do weekly nursing visits to monitor quality during outpatient rehabilitation episodes", and so on (I am inventing these examples for illustration purposes, but you get the idea). There are two general implications to this. First, a senior's income and assets will purchase less and less over the coming years. Second, the number of providers will be gradually reduced as fewer and fewer are able to survive while margins are compressed. This compression will occur from two sides; First, providers will need to subsidize losses on government programs by raising prices to private pay consumers. Second, private pay consumers will become scarcer as their dollars buy less and less, forcing them into these programs sooner.

So what does this inevitability mean for the industry, and more specifically for providers? As these programs add on requirements to providers, costs will rise. For example, you as the provider may need to provide 24 hour telehealth monitoring as "quality control" to be reimbursed $50 by Medicaid for a med box fill (extreme, but not out of the realm of possibility). We have only three options as providers (other than go out of business or sell):

1. **Increase price to the consumer**. We have already stated that reimbursements will be capped, if not cut, as a way to fund the current gap in these programs. That leaves the only other option as raising private pay prices to subsidize increased cost of operations. This may help as a Band-Aid, but competition will create downward price pressure, making this strategy relatively ineffective. Ultimately, this approach will simply drive consumers into these programs faster. Leaving us in the same place as when we started. So let's throw price increase out as an option.
2. **Reduce quality**. I won't spend any time on this option, but rather I'll assume that if you're the type of person reading this article, you are not the type that will lower your standards. Additionally, competition should drive lower quality providers out of the industry (assuming the government doesn't switch to monopoly-like licensing).

The third option is the one that I would suggest we must embrace and pursue.



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3. **Specialize, Innovate, and Collaborate**. Economizing (i.e. become more efficient) on the very limited resources each provider will have is the only way to do more with less. We need providers to select an area of focus, and develop innovations that will allow them to perform a particular function two or three times more efficiently than others can. Along what lines it is valuable to specialize will become evident when we as an industry begin doing what we are uncomfortable with, collaborating. Cooperative agreements, partnerships, and joint ventures need to become the norm within the industry. These forms of collaboration give the counter party the confidence that there is a niche market to sell to, allowing them to make the risky investments needed to innovate. For example, there may be a provider that figures out how to do medication management at a fraction of the cost that your agency can. Embrace that, and partner with that provider. Let that small and inefficient piece of your business go. Now I know that there are regulatory barriers to some types of partnership, complicating it further is these restrictions are unique to each provider type; however, these are the arguments we need to be making to legislators and regulators. Forget arguing with them over reimbursement increases. Those arguments are already falling on deaf ears. Tell them that "if you want us to provide for this price, you have to allow us the ability to innovate through collaboration and specialization!"

I welcome your thoughts, ideas, comments and feedback. Feel free to contact me directly at the email address below.

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